TOWARD A MODEL OF SUBJECTIVE RESEARCH

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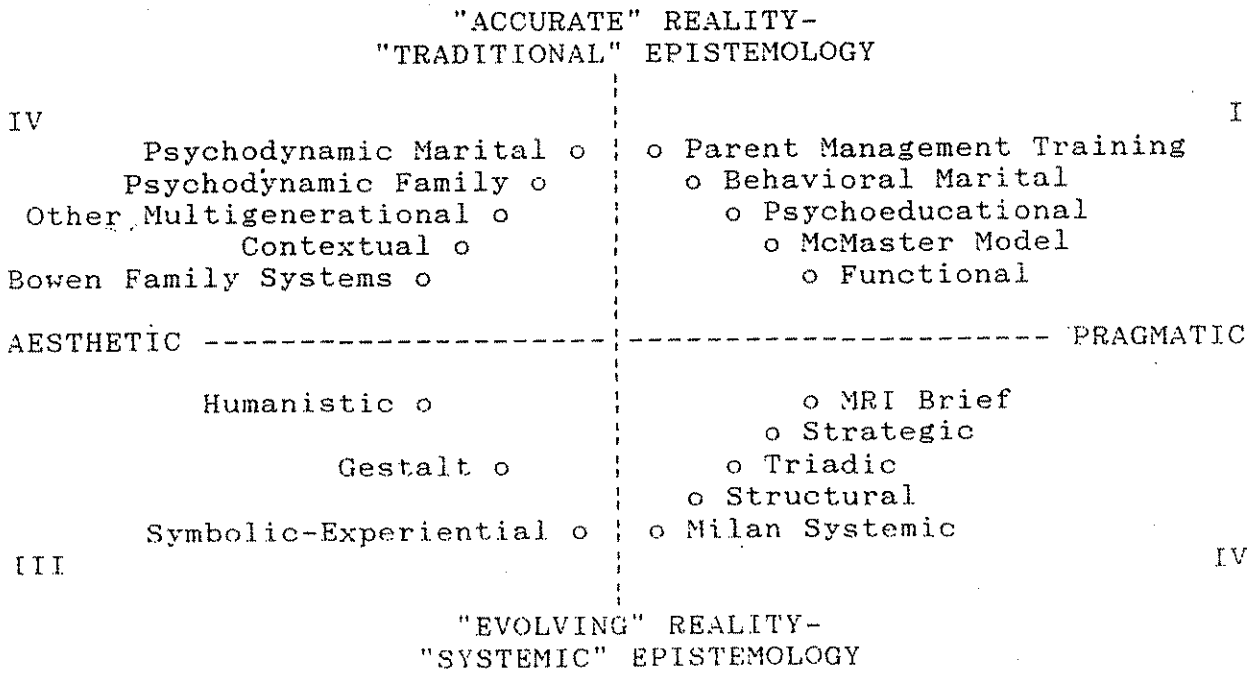
In 1985 at the annual conference of the American Family Therapy Association, Alan Gurman, Ph.D., presented a chart - a wheel - representing amounts of research which have been accomplished into the various practices of family therapy. This presentation was about follow-up research, and his wheel is reproduced below:



Now what was striking in this for me was that there was a whole quadrant of the wheel for which no follow-up research had been done. What's more, it is the quadrant into which my own work falls. As I thought about it, I realized that quadrant, and that alone, had neither boundary involved with linear temporality; rather the two arms of that quadrant represented orientations whose temporal organization is synchronistic. It suddenly hit me that the notion of 'follow-up' necessarily involves linear temporality, and so by definition, no such research could be visited successfully upon those therapies.

This recognition kindled further in me a small flame which for some years had been nudging me. I have for 13 years been a practitioner of Zen meditation and have been inclined to consider the observations which I make internally in a meditative state to match in rigor and clarity the observations offered by traditional empirical research. When Alan Gurman presented his chart, I realized where these intimations of an introspective kind of research fit into the scheme of things.

What I propose, then, is a research model for therapies which reside within that third quadrant - a model of research, in ways, stand follow-up research on its head. It is a model whose basis is subjective, introspective experience within the tight discipline of Zen meditation.

Let me explain what about Zen suggests itself as a context for this form of research. Zen, as a practice, is concerned with the disidentification of one's self with intellectual experience, the identification of self with the non-rational (or intuitive) aspect of experience, and eventually dropping identification and self as constructs of experience altogether. One can enter a rather pure state of intuitive consciousness. From this experience the self can be re-summoned to awareness, together with the intellect, and with these elements we can point with words toward the experience of intuitive consciousness.

How does this work? The clinician in Quadrant III modes of therapy takes as his or her target the development of a ready acceptance in clients to meet with open eyes whatever comes to their lives and their cultivation of an harmonious inner life. The sine qua non of these two qualities are the processes of becoming in touch with non-rational consciousness [1] and laboring to make intellectual formulations describe accurately [2] the

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1. This may be understood as instinct, intuition, spirituality, and in other terms, depending on the idiom of the experiencer. Rational consciousness is understood as the cookie-cutter with which we designate certain parts of our experience for our attention and the capacity with which we label and evaluate our non-rational experience.

2. In as far as is possible, given the inherent differences between the two modes.

perceptions of non-rational consciousness. [3] This accomplished, a person is open to perceive what is, and in harmony within (rational and non-rational consciousness being aligned).

Our subjective research perch allows us to experience the non-rational of our consciousness and on the way back to a bi-modal state of consciousness to check on the seam between rational and non-rational and discern whether or not the rational is lying soundly over the non-rational or intuitive. If it has not done so in our experiencing of ourselves, then we have found a flaw in our work; if it has, success. If it has not done so in our similar process of perception of our clients, then we have found a trouble spot; if it has, areas of well-being. This set of observational stances is part of the therapeutic process itself, generating as well its own research. For beginning notes on a new understanding of human difficulties based on these perceptions, see Appendix.

Research arrived at in this way derives its validity not from its repeatability or from the objectivity of the researcher with regard to his subject, but from the singular unity of the research with his/her subject of study and the forsaking of his/her experience of self in the process.

This proposal for a research model involves three significant differences from traditional follow-up research: 1) The researcher and the clinician are one and the same person; 2) The research is carried out <u>at the same time</u> as the clinical work; 3) The field of study is <u>internal</u> to the researcher.

How is the therapist to know, him/herself, whether he/she has been congruent? These therapies have all always assumed an introspective stance on the part of the therapist and demanded his greatest inner clarity and honesty. This can be expressed more specifically by stating two tenets which the therapist practicing in this quadrant needs uphold: 1) the practice on a regular basis of a repetitive activity (meditation, jogging, swimming laps, saying the Rosary, as examples) which has the effect of shutting down rational consciousness and exposing him/her with ever more clarity to non-rational perceptions; and 2) the on-going effort to find words and actions which fit more and more closely his/her non-rational perceptions.

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3. Another way to say this would be the frequently-employed term "authenticity as descriptive of the optimal state of the therapist.

In this suggested research model for Quadrant III therapy, the clinician is his/her own researcher, looking inward in a rigorously prescribed way in the present of his/her exchange with clients. This sort of study acts as a check for the clinician and informs him/her of the ways in which he/she must still tighten the clinical ship.

Appendix

Two Diagnostic Categories Understood in the Light of the Fit of Rational and Non-rational Consciousness

Manic-Depressive Syndrome:

The person has gotten into the habit of 'hyping' his/her highs, riding them for all they are worth. Faithfulness to the totality of non-rational experience is left as the client more and more eclipses less agreeable aspects of experience and centers on and magnifies the 'highs', toward peak experience. This client can be taught to even out his emotional and chemical states by nipping the 'high' in the bud, quelling it as with a candle snuffer the minute he/she begins to become aware of it (awareness must be brought to earlier and earlier points in the process). The client thereby regains a more balanced consciousness of all of his/her present experience. The difficulty for the client is denying him/herself something so pleasing. This practice will level out inner experience to a rich and steady hum far superior in productivity to the on-off cycle of elation and depression.

Paranoid Syndrome:

Here a person with a high degree of awareness of his/her non-rational perceptions finds him/herself surrounded with people who are <u>not</u> sensitive to these elements of consciousness. The breadth of his/her non-rational perceptions is denied by people focused on the more rational elements of consciousness. In this way the person's reality is denied (thus the anger) and he/she receives no help in the important process of refining the non-rational perceptions and distinguishing them from other experience, viz., emotions [1] (hence the wildly wide-of-the-mark quality of some of the perceptions taken as intuitively accurate). An educational process must occur in which the non-rational perceptions of this person are honored and separated from rational process (including emotions) so that the person can begin to use what he/she knows to good effect.

Other diagnostic categories are currently being worked out in these terms.

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1. In this model, emotions are considered part of rational consciousness, being visceral reactions to thought forms or frames of reference placed on experience.